Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Alta Vista Healthcare 5445 La Sierra Dr., #204 Dallas, TX 75231	MFDR Tracking #: M4-07-3077-01 DWC Claim #: Injured Employe
Respondent Name and Box #: Texas Mutual Insurance Co. Rep. Box #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "CPT Code was paid below MAR. This was resubmitted via fax on 06/13/06 but as of today we have not received any payment or second denial EOB. Per Rule 134.202(e)(4) there is not a maximum benefit for this particular CPT Code. Reimbursement is recommended per Rule 134.202(d)(2), MAR i2 $35.51 per unit..."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $177.54
3. CMS 1500(s)
4. EOB(s)

Sent
SEP 11 2007
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: A response was not received from the Respondent.

PART IV: SUMMARY OF FINDINGS

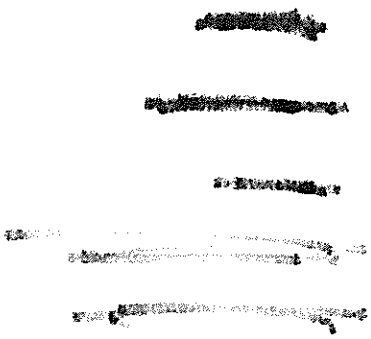
Eligible Dates of Service (DOS)	CPT Code(s) and Calculations	Part V Reference	Amount in Dispute	Ordered Amount
03/16/06	97750 ($28.41 x 125% x 5)	1, 2	177.54	$177.54
Total Due:				$177.54

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines

1. These services were denied by the Respondent with reason code "42 – Charges exceed our fee schedule or maximum allowable amount" and "790 – This charges was reduced in accordance to the Texas Medical Fee Guideline."

2. Per Rule 134.202(b) CPT Code 97750 is billed in 15 minute increments. The Requestor billed 7 units and was reimbursed for 2. The maximum allowable reimbursement for each unit is $35.51 ($28.41 x 125%); the requestor is seeking additional reimbursement according to the fee guideline. Therefore, additional



2. reimbursement in the amount of $177.54 is recommended per Rule 134.202(c)(1).

3. Per review of Box 32 on CMS-1500, zip code 78212 is located in Bexar County.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sec. §134.1, §134.202
Subchapter G, Chapter 2001, Texas Government Code

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, section §413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $177.54 plus applicable accrued interest per Division Rule 134.803 due within 30 days of receipt of this Order.

ORDER:

Authorized Signature — Team Lead, Medical Fee Dispute Resolution — September 10, 2007 (Date)

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.